COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

TRANSITION COORDINATOR

HOME AND COMMUNITY BASED CARE SERVICES

ENROLLMENT PACKAGE

Contents:

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First Health Services Corporation
A Coventry Health Care Company

Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents. If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires covered health care providers to obtain and use a new 10 digit National Provider Identifier (NPI) in lieu of any other provider identification number(s) for all standard transactions. DMAS is expanding this requirement to its entire provider network, including providers not considered health care providers as defined by the NPI Final Rule. DMAS is requiring this change for Atypical providers in order to maintain the consistency and integrity of its Medical Management Information System.

Your provider category has been identified as an Atypical provider category. As such you will be assigned a 10-digit Atypical Provider Identifier (API) for you to use when your application is approved. Your new 10-digit API number is to be used on all Medicaid business transactions. (Claims, ARS, PA), including paper claims. Please note, the '1D' ID Qualifier must be used in fields 24I, 32b and 33b when submitting the new CMS-1500 version 08/05 because Atypical Providers are not required to submit an NPI.

Some Atypical Providers may have successfully obtained an NPI because they provide other services that qualify them as a healthcare provider according to the HIPAA rules. If this is the case and you have obtained an NPI, your NPI will supercede the DMAS assigned API. Please download the Atypical Provider NPI Attestation Form from the DMAS Website at http://www.dmas.virginia.gov/downloads/pdfs/hpa-npi_Atypical_Enum_Letter.pdf and follow the instructions in order to notify DMAS of your NPI.

Out-of-State Enrollment in Virginia Medical Assistance Programs

Adult Day Health Care providers must be located within the Commonwealth of Virginia. Out-of-state providers are not eligible for this Virginia Medical Assistance Program.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at www.dmas.virginia.gov. **All applicants should visit the Virginia Department of Medical Assistance Services website and review the manual(s) for their specific provider type.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation
A Coventry Health Care Company

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. National Provider Identifier (NPI)

Enter your 10-digit NPI as assigned by the National Plan and Provider Enumeration System (NPPES). If you are a business, enter your organization (Type 2) NPI. If you are an individual, enter your individual (Type 1) NPI. If you are an Atypical provider, leave this section blank.

2. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. If you have entered an organization (Type 2) NPI in field #1, you must enter a business name. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). If you have entered a Type 1 NPI in field #1, you must enter an individual name. This name is used to generate claim payments and report 1099 information.

3. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

4. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group NPI, or you are individually incorporated.

5. IRS Name

Enter your IRS Name as it is registered with the IRS.

6. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this section blank.

7. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

8. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

9. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

10. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

11. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

12. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Number of Beds

If you are an institution, enter the number of beds for each type.

17. Administrator's Name

The name of the administrator of your practice or facility.

Remarks

Enter any additional information or comments in the Remarks section of pages 1, 2 or both.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation
A Coventry Health Care Company

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Medical Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.virginia.gov.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. Enter your Primary Servicing Address in the Primary Servicing Address block on the Address Form

Note: For providers who are members of a Group Practice, enter the servicing address at which you practice and the Group NPI of the billing group that bills for your services rendered at that address.

2. Correspondence Address (Mandatory)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the ***Primary*** Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Correspondence Address. If there is no entry in the Correspondence Address section, the Remittance Advice will be sent to the ***Primary*** Servicing Address.

For First Health's Use Only

Tracking Number_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. NATIONAL PROVIDER IDENTIFIER _____

2. LEGAL BUSINESS NAME: _____
(If applicable, as registered with the Internal Revenue Service)

OR

INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
(Name of the provider who performs the service)

3. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

4. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

5. IRS NAME _____

6. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

7. PROVIDER PROGRAM: ___ **Medicaid** ___ **Medallion** ___ **Medallion II** ___ **State and Local Hospital (SLH)**

___ **Client Medical Management (CMM)**

___ **Temporary Detention Order (TDO)**

___ **Family Access to Medical Insurance Security Plan (FAMIS)**

8. REQUESTED EFFECTIVE DATE OF ENROLLMENT _____

REMARKS:
_____

_____

_____

_____

9. LICENSE/CERTIFICATION NUMBER _____ **LICENSING BOARD** _____

ISSUING STATE AND ENTITY _____

10. PRIMARY SPECIALTY _____ **LICENSING BOARD** _____

SECONDARY SPECIALTY _____ **LICENSING BOARD** _____

11. FDA MAMMOGRAPHY CERTIFICATION NUMBER _____

12. CLIA NUMBER _____

13. TYPE OF APPLICANT (Please check one)

___ Individual ___ Corporation ___ Hospital Based Physician ___ Sole Proprietorship

___ Group Practice ___ Partnership ___ Health Maintenance Organization (HMO)

___ Limited Liability Partner

14. FACILITY RATING (Please check one)

___ Profit ___ Non-Profit ___ Not Applicable

15. FACILITY CONTROL (Please check one)

___ State ___ Private ___ Public

___ City ___ Charity ___ Not Applicable

16. NUMBER OF BEDS

___ NF ___ SNF-NF ___ SNF

___ Non-Cert ___ ICF-MR ___ Specialized Care

17. ADMINISTRATOR'S NAME _____

REMARKS:

_____

_____

_____

_____

SIGNATURE _____ **DATE** _____

ADDRESS FORM

PROVIDER NAME _____ **NPI** _____

PRIMARY SERVICING ADDRESS (Physical location where provider renders services)

If you are a member of a group practice, enter the *group NPI* for this servicing address: _____

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Home and Community Based Care Services Transition Coordinator Participation Agreement

This is to certify:

Provider Name _____ API/NPI _____
(Leave blank if unknown))

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.**
9. **Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.**
10. **Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.**
13. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*
Director, Division of Program Operations Date

Original Signature of Provider **Date**

First Health Services Corporation

HOME AND COMMUNITY-BASED CARE APPLICATION FOR PROVIDER STATUS AS A TRANSITION COORDINATOR CARE PROVIDER

Name your agency will do business as:

_____

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Transition Coordinator services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes **No**

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

2. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE TRANSITION COORDINATOR PERSONNEL (Fill in all that apply.)

_____ _____ _____

Provider responsible for signing contract Title Phone number

This, Transition Coordinator provider is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Administrator On-site Title Phone number

This, Transition Coordinator provider is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Other On-site Contact Person Title Phone number

This, Transition Coordinator provider is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____

Chief Corporate Officer Title Phone number

_____ _____ _____

Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____

_____ _____ _____

_____ _____ _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH) For Non-Profit Entities Section 501(c) (3), list the board members.

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any, Transition Coordinator provider listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

____ Durable Medical Equipment ____ Home Health ____ Social Work Services ____Hospice
____ Rehabilitation Services ____ Case Management ____ Others _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any, Transition Coordinator (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes** **No** .
If yes, explain the type of offense, name and title of individual:

_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of, Transition Coordinator signing application Print title

_____ _____
Signature of, Transition Coordinator signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR TRANSITION COORDINATOR

Transition Coordinator must meet the general conditions and requirements for home-based and community based care participating providers as specified in 12VAC30-120-217 and 12VAc30-120-219, transition coordinators shall meet the following qualifications:

1. **Transition coordinators shall be employed by one of the following: a local government agency; a private, nonprofit organization qualified under 26 USC 501 ©(3); or a fiscal management service with experience in providing this service.**
2. **A qualified transition coordinator shall possess, at a minimum, a bachelor's degree in human services or health care and relevant experience that indicates the individual possesses the following knowledge, skills, and abilities. These shall be documented on the transition coordinator's job or promotion interview. The transition coordinator shall be at least 21 years of age.**
   - **Knowledge. Transition coordinators shall have knowledge of aging, independent living, the impact of disabilities and transition planning; individual assessments (including psychosocial, health, and functional factors) and their uses in service planning, interviewing techniques, individuals' rights, local human and health service delivery systems, including support services and public benefits eligibility requirements, principles of human behavior and interpersonal relationships, interpersonal communication principles and techniques, general principles of file documentation, the service planning process, and the major components of a service plan.**
   - **Skills. Transition coordinators shall have skills in negotiating with individuals and service providers; observing, and reporting behaviors; identifying and documenting an individual's needs for resources, services and other assistance; identifying services within the established services system to meet the individual's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of the individual; and assessing individuals using DMAS' authorized assessment forms.**
   - **Abilities. Transition coordinators shall have the ability to demonstrate a positive regard for individuals and their families or designated guardian; be persistent and remain objective; work as a team member, maintaining effective interagency and intra-agency working relationships' work independently, performing position duties under general supervision; communicate effectively, both verbally and in writing; develop a rapport; communicate with different types of persons from diverse cultural backgrounds; and conduct interviews.**

1. List below the person who will be responsible for daily management of the Transition Coordinator program and who they report to:

_____ _____ _____

Name Title Phone Number

Reports to: _____ _____

Phone Number

_____ _____ _____

Name Title Phone Number

Reports to: _____ _____

Phone Number

First Health Services Corporation
A Coventry Health Care Company

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ❑ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ❑ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ❑ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

NPI/API: _____

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation
A Coventry Health Care Company

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each NPI or API as appropriate.
- **All** payments for each NPI or API must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

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Electronic Funds Transfer Application

GENERAL INFORMATION

_____
Provider Name

_____
Remittance Address City State Zip

Authorization Agreement for Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following Provider ID:**

NPI or API as appropriate	**Tax ID Number**

Printed Name **Title**

Signature **Date**

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE